

- 3 Gibb WR, Urry PA, Lees AJ. Giant cell arteritis with spinal cord infarction and basilar artery thrombosis. *J Neurol Neurosurg Psychiatry* 1985;48:945-8.
- 4 Kjeldsen MH, Reske-Neilsen E. Pathological changes of the central nervous system in giant-cell arteritis. *Acta Ophthalmol* 1968;46:49-56.
- 5 Morrison AN, Abitbol M. Granulomatous arteritis with myocardial infarction: a case report with autopsy findings. *Ann Intern Med* 1955;42:691-700.
- 6 Gordon RM, Bender MB. Visual phenomena in lesions of the median longitudinal fasciculus. *Arch Neurol* 1966;15:238-40.

Chronic fatigue syndrome

As neurologists in a country where the chronic fatigue syndrome (CFS) has almost no recognized official existence, we often feel bewildered by the papers on the subject we read in the Anglo-Saxon literature. We wonder whether the clinical experience of some of their authors is so different from ours that they do not consider that their approach may result in a disservice to their patients. The JNNP has followed a sensitive line culminating in Wessely's excellent editorial.¹ We still, however, feel that his kid-glove handling of the subject reflects the controversy that surrounds it in the UK.

Avoiding the futile organic versus functional debate, in our neurology department we refer to many of the problems we see in our practice as the "chronic vigilance syndromes": specific patterns of enhanced attention centred on particular bodily structures and functions. Naturally, the commonest in a neurologist's outpatient clinic are the "cephalic vigilance syndromes" in their two main forms: the painful, with its several varieties of chronic headaches, and the operational one with its subjective unsteadiness, concentration problems and various odd turns. "Thoracic vigilance" patients are often referred to cardiologists or pneumologists but a fair number also come to us, especially if they have hyperventilation symptoms such as dizziness and paraesthesiae. Among the different types of patients with fatigue we are also familiar with the occasional "neuro-muscular vigilance" patient whose symptoms parallel your CFS cases. We have the non-controlled impression that in our environment such patients often have a premonitory preoccupation with their locomotor system.

We believe that an important element in all these syndromes consists of the patients' misconceptions about the causes, mechanisms and prognosis of their symptoms derived from popular health concepts and also not infrequently from counterproductive health education campaigns and doctors' remarks. In fact, we find it remarkable that the influence of the public and medical interest in CFS on its proliferation does not figure prominently in any discussion. That is why our approach to these syndromes consists mainly of a kind of "cognitive therapy" which tries to bring to the fore the patient's ideas on the problem and to demolish misconceptions, together with a sparing use of drugs. Our experience tells us that whereas some of these syndromes can be dealt with reasonably well, others are much more resistant. Such is the case for example with the "facial vigilance syndrome", better known as atypical facial pain, and the "neuromuscular vigilance syn-

drome". Fortunately the latter is not common in our environment.

But not for long. Our compatriots are starting to be taught about this "new" disease. The widely read Madrid newspaper *El Pais* ran a full page story on the CFS as "the disease of the nineties". A highly-reputed private teaching hospital has also given press releases on this "impending epidemic" and even a local newspaper has informed our neighbourhood about the shape of things to come. Some months ago a chat-show on Spanish television hosted the "first" Spanish patient with CFS.

So now we are bracing ourselves. Wessely quotes an article on "the role of culture in making a diagnosis".² There is also a role for culture in developing and expressing illness. Our colleagues are being educated in this new pattern of self-vigilance, and the successful incorporation of Spain into the Western democracies will be enriched by this new cultural acquisition. They will also be taught that this disease is chronic, long-lasting, makes inactivity advisable and has no treatment: a self-fulfilling recipe for chronicity. They will learn to mistrust doctors who suggest that their symptoms, real, disabling and worthy of treatment as they are recognised to be, may not be due to a testable specific organ disease: a mistrust that will deny them the first step towards improvement. And presumably we Spanish doctors will soon start publishing papers on CFS.

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- 1 Wessely S. Chronic fatigue syndrome. *J Neurol Neurosurg Psychiatry* 1991;54:669-71.
- 2 Abbey S, Garfinkel P. Neurasthenia and chronic fatigue syndrome: the role of culture in the making of a diagnosis. *Am J Psychiatry* (in press).

Wessely replies:

Dr Digon and colleagues believe that cultural factors play a vital role in the aetiology of CFS, a view I can only share. There is a considerable degree of iatrogenesis in the rise of these conditions, and if one is to understand their sudden rise, and occasional fall, it is essential to understand cultural attitudes towards health and illness, and in particular prejudice against conditions which, whether fairly or not, are frequently seen as psychological in origin.¹² We have previously concluded that such prejudices and unhelpful polarisation between "physical or psychological", which all too often means "real or unreal", may be more virulent than any virus.³

- 1 Wessely S. History of postviral fatigue syndrome. *Br Med Bull* 1991;47:919-41.
- 2 Wessely S. "Old Wine in New Bottles": neurasthenia and ME. *Psychological Medicine* 1990;20:35-53.
- 3 David A, Wessely S, Pelosi A. Chronic fatigue syndrome: signs of a new approach. *Br J Hosp Med* 1991;45:158-63.

BOOK REVIEWS

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Post-Viral Fatigue Syndrome. Edited by R JENKINS AND J MOWBRAY. (Pp 463; Price £60.00). Chichester, John Wiley & Sons Ltd, 1991. ISBN 0 471 928461.

What is regarded as increasing enlightenment, or perhaps an increased journalistic interest in medical matters, has led to much more "self-diagnosis" in the Neurology Clinics. One of the more popular diagnostic labels attached to the patient by himself or his informed friends, is myalgic encephalomyelitis or ME.

Many patients attending the clinic, convinced of the correctness of the diagnosis will bring evidence of confirmation from specialist practitioners and organised groups and will not be persuaded otherwise. They will not accept that there is an alternative explanation for their problems to "post-viral fatigue" or whatever. These patients pose a considerable problem. It is not surprising that an attempt has been made to rationalise this "syndrome", to give it an identity as a nosological entity, consider the pathogenesis, importance, and implications and to define the diagnostic criteria.

This book is edited by a principal medical officer at the department of health, a psychiatrist by training and a professor of immunopathology. They have invited contributors from diverse backgrounds to discuss their involvement in ME and to resolve the "particularly challenging problem for contemporary medicine... those puzzling clinical entities which are defined purely in terms of symptoms, which are accompanied by little in the way of consistent physical signs, which affect quite large numbers of patients for which no specific treatment appears effective".

Thirty-five contributors address the problem in a book of 275 pages. It is stated unequivocally on page 167... "it is however beyond any doubt that muscles are involved in this syndrome with both metabolic and ultrastructural abnormalities" and yet on page 237 the more orthodox neurological view is expressed... "our management of patients... is based on our belief that the condition forms part of the spectrum of a depressive illness, triggered by a viral infection". The psychologist, recognising that it has "attracted much controversy" concludes that it is not clear whether we are dealing with a single syndrome or with a heterogeneous group of disorders which share some common characteristics.